

**U.S. Department of Labor**

Office of Administrative Law Judges  
Heritage Plaza Bldg. - Suite 530  
111 Veterans Memorial Blvd  
Metairie, LA 70005

(504) 589-6201  
(504) 589-6268 (FAX)



Issue date: 13Mar2002

CASE NO.: 2000-LHC-851

OWCP NO.: 08-116801

IN THE MATTER OF

EDDIE L. MINIX,  
Claimant

v.

TDI HALTER, INC.,  
Employer

and

RELIANCE NATIONAL INDEMNITY,  
Carrier

APPEARANCES:

Gary Pitts, Esq.  
On behalf of the Claimant

Dennis J. Sullivan, Esq.  
On behalf of the Employer and Carrier

Before: Clement J. Kennington  
Administrative Law Judge

**DECISION AND ORDER DENYING BENEFITS**

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901, *et. seq.*, brought by Eddie L. Minix (Claimant), against TDI Halter, Inc. (Employer) and Reliance National Indemnity, (Carrier). The issues raised by the parties could not be

resolved administratively, and the matter was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held before me on April 3, 2001, in Houston, Texas.

At the hearing all parties were afforded the opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs in support of their positions. Claimant testified and introduced eleven exhibits, all of which were admitted into evidence, (CX-3-4, 6-8, 11-15, and 21), including: notes from Employer's safety supervisor, Richard Broussard, dated July 2 & 30, 1999; Employer's first report of injury; Claimant's pre-employment drug screen; Claimant's report for a medical leave of absence; a fifty-two-week wage history of Claimant while working for Employer; Claimant's social security records; Employer's responses to interrogatories; objections and responses to Claimant's request for admissions; and a report from the Texas Rehabilitation Commission regarding a Residual Functional Capacity Assessment.<sup>1</sup> Claimant also presented testimony from himself, his wife, Bernadine Minix, and his sister, Hattie Bailey.

Employer introduced seventeen exhibits, (EX-1 to EX-17) which were admitted into evidence, including: medical reports related to Claimant's treatment; Claimant's pharmaceutical records; Dr. Martin Haig's January 30, 2001, medical report; vocational rehabilitation expert, Ms. Deborah Miller Smith's testimony and reports dated October 18, 2000, February 21, 2001, and March 28, 2001; Claimant's wage report from Employer from September 13, 1998 to June 13, 1999; Claimant's IRS records; relevant United States Department of Labor filings; Employee witness statements of July 2 & 30, 1999; Claimant's personnel file; excerpts from the Texas Workforce Commission records; medical records from Drs. Colin Hales, Forney Fleming, Bryan Williamson and Jack Johnston; the March 13, 2001 deposition of Dr. Martin Haig; and Employer handbooks reviewing work rules.

Post-hearing briefs were filed by the parties. Based upon the stipulations of the parties, the evidence introduced, my observation of the witnesses' demeanor, and the arguments presented, I make the following Findings of Fact, Conclusions of Law, and Order.

## **I. STIPULATIONS**

At the commencement of the hearing, the parties stipulated (JX-1) and I find:

1. An Employer/Employee relationship existed from September 9, 1998, to September 24, 1999, the time encompassing the disputed or alleged accident;

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<sup>1</sup> References to the transcript and exhibits are as follows: hearing transcript-Tr.\_\_\_\_; Claimant's exhibits- CX\_\_\_\_, p.\_\_\_\_; Employer's exhibits-EX\_\_\_\_, p.\_\_\_\_.

2. Employer controverted the claim on August 18, 1999;
3. An informal conference was held in connection with this matter on October 26, 1999;
4. Maximum medical improvement was reached November 17, 1999, as established by Dr. Bryan Williamson;
5. Employer paid no compensations or medical benefits to Claimant as a result of Claimant's alleged injury;
6. The alleged injury, assuming it occurred, comes within the jurisdiction of the Act;
7. Claimant's average weekly wage at the time of the alleged injury was \$504.17.

## **II. ISSUES**

The following unresolved issues were presented by the parties:

1. Whether Claimant suffered an injury in the course and scope of his employment;
2. Whether Claimant advised Employer/Carrier of his alleged back and neck injuries on June 14, 1999, as contended by Claimant, or on July, 2 & 30, 1999, as contended by Employer;
3. Nature and extent of disability;
4. Loss of wage earning capacity;
5. Attorney's fees and interest.

## **III. STATEMENT OF THE CASE**

### **A. Chronology:**

Claimant is a forty-one-year-old married male with two felony convictions and incarcerations in 1978 and 1989 for distribution of barbiturates and marijuana. (Tr. 19, 56, 57). Prior to working for Employer, Claimant worked as a construction welder from 1978-1982 and a burner for a scrap metal company, Port Iron. (Tr. 20). On September 13, 1998, Claimant began working for Employer as a

pipefitter helper. (Tr. 19-25; EX-7, p. 1). In June of 1999, Employer transferred Claimant from Orange, Texas to a dry dock facility in Port Arthur, Texas, where it assigned him pipefitting duties on an oil rig that required him to climb in and out of portholes. (Tr. 26-27). Claimant worked at this facility until June 12, 1999. On June 22, 1999, Employer terminated Claimant for failing to report to work. On June 29, 1999, Claimant was apparently rehired after securing a medical leave of absence effective from June 14, through August 16, 1999. When Claimant failed to report to work after August 16, 1999, he was again terminated on October 1, 1999. (EX-12, pp. 14-17, 124-25).

Claimant's medical history surrounding the alleged injury is as follows: On June 14, 1999, Claimant went to the emergency room (ER) with a headache, sore throat and fever. (EX-1, pp. 11-16; EX-7; Tr. 69-70). Claimant was diagnosed with sinusitis and a respiratory infection and referred to his family doctor. (Tr. 77; EX-1, pp. 11-16). His family physician, Dr. Rizalino Reyes, treated Claimant on June 14, 15, 17, & 22, 1999. The initial complaints consisted of chills, fever, weak legs, numbness and tingling in the right and left arm and Dr. Reyes treated Claimant for an impacted left ear canal. (EX-1, pp. 26-27). On the June 22 visit Claimant, for the first time, complained of back pain and underwent lumbosacral x-rays which revealed a congenital spinal defect. (EX-1, pp. 28-34).<sup>2</sup>

On June 29, 1999, Claimant presented to Dr. Forney W. Fleming, an orthopaedic surgeon, with bilateral knee pain secondary to back pain and hand numbness. (EX-1, p. 36-37). Dr. Fleming ordered MRIs of both knees and referred Claimant to Dr. Jack Johnston for further evaluation.<sup>3</sup> *Id.* On July 5, 1999, Claimant saw Dr. Johnston, who in turn ordered brain, cervical, and lumbar MRIs and prescribed medication as well as a dose pack to relieve pain. (EX-1, pp. 41-45). On July 7, 1999, a brain MRI was completed, which indicated no significant abnormalities. A cervical MRI, however, indicated marked cervical cord compression changes secondary to a large central intervertebral disc herniation at the C4-C5 level and a smaller disc herniation at the C3-C4 level, which had resulted in focal spinal stenosis at those

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<sup>2</sup> On July 2, 1999, Claimant completed Employer's Accident Investigation Witness Statement, asserting for the first time that he injured his back at work, sometime between June 10, 1999, and June 13, 1999, when he was climbing into a hole, which did not have a hand platform and required Claimant to go in feet first. (Tr. 28, 120, 129; EX-10). While descending, Claimant's feet slipped because he allowed his feet to dangle before planting them onto a ladder, and with one hand hanging onto a rail, he felt a twinge in his lower back. (Tr. 28; EX-10). On July 30, 1999, Claimant completed a second Accident Investigation Witness Statement, claiming cervical problems he had begun experiencing were related to bumping his head on pipes while in rig holes. Both of these reports were provided to Richard Broussard, Employer's head of safety personnel. (Tr.34).

<sup>3</sup> It is unclear from the record whether the knee MRI was completed during and/or around that time period. (Tr. 95-96; EX-1, p.48). Although, the record is clear that Claimant ultimately admitted his knee problems were not work related. (EX-4).

levels. A lumbar spine MRI indicated an intervertebral disc extrusion at the L5-S1 level and a central disc protrusion at L4-L5. Dr. Johnston subsequently reviewed the MRI results with Claimant, informed Claimant that he had back and neck problems, and referred Claimant to see Dr. J. Bryan Williamson. (Tr. 129; EX-1, pp. 42-47).

On July 23, 1999, Claimant saw Dr. Colin Hales, a family physician, due to five days of reported headaches. (EX-1, pp. 79-80). Dr. Hales examined Claimant and prescribed Vicodin for pain. Dr. Hales continued to follow Claimant on a monthly basis, up until the date of the hearing, for general care and medication administration. (EX-14, pp. 4-8).

On July 26, 1999, Claimant presented to Dr. Williamson with headaches; neck pain; low back pain; tingling and numbness in both hands; and stiffness in both wrists. (EX-1, pp. 50-68). Claimant reported to Dr. Williamson that he had a lifetime history of heavy work with intermittent lower back pain associated with his employment, and on June 14, 1999, he experienced total body tiredness and weakness, followed by profuse sweating on June 21, 1999, while working around his house. Claimant told Dr. Williams that his work over the last several months had required him to frequently change positions as he climbed up and down and moved throughout tunnels. This activity caused him problems resulting in: slower functioning; neck pain; intermittent numbness and tingling in the upper extremities; trouble balancing, frequent urination; and persistent lower back pain which radiated into the left leg; and severe headaches over the past five days requiring use of Vicodin and Excedrin. (EX-1, p.65, Tr. 106-108, 116). Claimant attributed the increase neck and back pain to his attempt to get out of a ship hole on June 7, 1999. (EX-1, p. 68).

Dr. Williamson reviewed the x-rays and MRIs taken of Claimant's cervical and lumbar spine in June and July of 1999, and diagnosed Claimant with headaches, cervical congenital canal stenosis, most pronounced at C3-4 and C4-5, myomalacia within his cervical cord, lumbar degenerative changes at L4-5 and L5-S1. (EX-1, p. 67). Additionally, Dr. Williamson found L4 and S1 radiculopathy, with right L4 and S1 radicular patterns. *Id.* Based on Claimant's overall weakness, the myomalacia in his cord and the congenital narrowing within his cervical spine, Dr. Williamson recommended surgical intervention. Dr. Williamson also recommended that Claimant's lower lumbar spine be treated conservatively with exercises, physical therapy and possible epidural steroid injections. Dr. Williamson placed Claimant on steroids to provide pain relief and put Claimant in a soft cervical collar for his neck. He opined that Claimant would not be able to return to his prior heavy duty employment. Dr. Williamson also recommended that Claimant follow-up with a neurologist if his headaches persisted. (EX-1, p.67).

On August 4, 1999, Claimant was admitted to Park Place Hospital by Dr. Hales for pre-surgery clearance for his upcoming discectomy and fusion performed by Dr. Williamson. Dr. Hales ordered chest x-rays, which produced normal results, and prescribed Vicodin for pain. (EX-1, pp. 71-78). On August 20, 1999, Dr. Williamson performed an anterior cervical discectomy and fusion to treat Claimant's congenital cervical stenosis. (EX-1, pp. 77-92). On August 27, 1999, Dr. Williamson noted Claimant reacted positive for Hepatitis C and informed Claimant of such in a certified letter, which was duly received

and signed for by Claimant on September 7, 1999. (EX-1, p. 93). On August 30, 1999, Claimant returned to see Dr. Williamson with pain in his neck and right shoulder. Dr. Williamson noted Claimant's strength in his right upper extremity was improved and his MRI was not impressive for compression within the right upper extremity. This suggested to Dr. Williamson that an underlying C5 root irritation on the right hand side was causing Claimant's pain. On September 3, 1999, Claimant underwent another CT/myelogram, indicating status post decompression, resolving right C5 radiculopathy, and relative canal stenosis. (EX-1, pp. 98-101).

On September 9, 1999, a pharmacist contacted Dr. Hales' office because Claimant was getting prescriptions for pain medication filled from two different physicians. The pharmacist refused to fill a prescription for Tylenol #3 from Dr. Hales because Claimant had prescriptions for #40 Vicodin filled on August 23, 27, and 31, 1999, and September 7, 1999. Dr. Hales called Claimant and explained that Claimant would have to follow with Dr. Williamson to fill a Tylenol #3 prescription. On the following day, Claimant underwent a successful right C5 root sleeve block followed two days later by a thoracic MRI which showed posterior spondylosis and facet hypertrophy with a mild posterior central protrusion at T7-8 and multiple level thoracic degenerative changes.

On September 16, 1999, Dr. Mohamed Vadva evaluated Claimant for his positive Hepatitis C test results, associating Claimant's risk factor for Hepatitis C with Claimant's history of intravenous drug abuse. (EX-1, p. 112). Dr. Vadva recommended Claimant return to see him in four weeks after the blood occult results were in.

On October 20, 1999, Claimant presented to Dr. Williamson with pain in his neck and right shoulder region and intermittent numbness and tingling in the palmar aspect of his right hand. Dr. Williamson completed x-rays, which indicated good alignment of Claimant's grafts and instrumentation, although his fusion was not solid on flexion/extension views. Dr. Williamson noted Claimant's right sided radiculopathy was resolving. Claimant continued to suffer from lumbar degenerative disc disease with lumbar radicular pattern and a history of myomalacia within his cord. (EX-1, p. 127). On the same day Claimant underwent another lumbar epidural steroid injection followed by electromyography in November, 1999. (EX-1, pp. 133, 137). On November 17, 1999, Dr. Williamson released Claimant to sedentary duty work with no lifting over 10 pounds, no bending, twisting or turning. (EX-1, p. 134).

Thereafter Claimant saw Dr. Williamson on December 15, 1999, and February 14, 2000. Exams on those days confirmed a degenerative lumbar condition associated with neck and back pain. (EX-1, pp. 141, 148). Dr. Williamson recommended continued steroid treatments for symptom relief with possible surgical intervention. A subsequent MRI performed on February 14, 2000, confirmed a moderate sized central disc herniation with right paracentral extension at the L5-S1 level, a small central disc herniation at the L4-5 level and degenerative disc disease changes at L4-5 and L5-S1 levels.

On February 22, 2000, upon referral from Dr. Williamson, Texas Orthopedic Hospital Rehabilitation Department gave Claimant a 14% impairment rating of his cervical spine, which figure

represented impairment due to limited range of motion only. (EX-1, p. 150). On February 29, 2000, Claimant received another epidural steroid injection in the L4-5 space from Dr. Uday Doctor. (EX-1, p. 156).

Claimant visited Dr. Williamson on February 25, March 13 & 22, and May 3, 2000. (EX-1, p. 158). Dr. Williamson recommended continued conservative treatment with an exercise and strengthening program, as well as steroid injections for pain. By May 3, 2000, Claimant's condition had improved with significant reduction in leg and back pain. (EX-1, p.164). However, in the same month Claimant was diagnosed with diabetes. (Tr. 111-12).

On July 15, 2000, Claimant presented to Park Place Hospital with back pain that had reportedly onset about one month prior. Claimant was prescribed Vioxx and Vicodin for pain. (EX-1, pp. 197-200). On July 17, 2000, Dr. Hales' office refused Claimant's request for additional Vicodin because Claimant had been prescribed Vicodin ES #35 on July 15, 2000. (EX-1, p. 195). On July 19, 2000, Claimant presented to Life Resource Psychiatric Center for depression treatment. He was admitted for a psychiatric medication evaluation and was prescribed Zoloft and Buspar by Dr. Tuttle on August 1, 2000. The record contains no information concerning what, if any, psychiatric treatment Claimant received between July 19, 2000, and August 1, 2000.

On August 7, 2000, Claimant went back to Dr. Williamson with complaints of interthoracic, low back, and lower extremity pain. (EX-1, p. 216). Claimant was also experiencing intermittent numbness and tingling into his upper extremities. Dr. Williamson noted Claimant's recent diagnosis of diabetes. Upon that August 7, 2000 examination, Dr. Williamson's findings were consistent with prior examinations, but for the added problem of degenerative changes within Claimant's thoracolumbar spine. Dr. Williamson had Claimant undergo a total body scan which indicated increased uptake in the medial component of the left knee and an abnormality in the mid thoracic region. Consequently, Dr. Williamson recommended an MRI with evaluation. Dr. Williamson also recommended another epidural steroid injection for pain relief in Claimant's lower extremities, which injection was completed on August 25, 2000. Claimant was also prescribed Vioxx, Trizec, Glucotrol and Vicodin for pain. (EX-1, p. 218).

On August 23, 2000, Claimant was evaluated by psychologist, Dr. David J. Wright (Wright), upon referral by Mr. Steve Goist of the Texas Rehabilitation Commission (TRC). Dr. Wright interviewed Claimant and administered the following tests: (1) the Wechsler Adult Intelligence Scale-Third Edition (WAIS-III); (2) the Wide Range Achievement Test-Revision Three (WRAT3); (3) the Wechsler Memory Scale-Third Edition (WMS-III); and (4) the Rorschach. Claimant reported that he would be unable to engage in extended physical activity due to his age and an injury to his neck and lower back, which were both allegedly sustained June 10, 1999. (EX-1 p. 222). Based on the tests' results and their interview, Wright diagnosed Claimant as a drug dependent individual with mild mental retardation. Dr. Wright described Claimant as a "survivor" and street smart" who had learned con artist skills at a young age but currently had difficulty practicing those skills due to age and long term deleterious defects of his life style. Dr. Wright determined that Claimant's rehabilitation potential was not particularly good, but he could

possibly fill a helper type position. (EX-1, pp. 222-224).

On August 24, 2000, upon referral by Dr. Johnston, Claimant had an MRI of his left knee, which indicated a tear in the medial meniscus, as well as joint effusion and osteoarthritic changes. An MRI of Claimant's right knee also indicated a small tear in the medial meniscus. (EX-14, pp. 35-36). Dr. Johnston performed a partial medial meniscectomy on Claimant's left knee on October 26, 2000, (EX-1, pp. 254-56). Claimant was discharged to home with exercise instructions for gait training with crutches and Vicodin and Celebrex for pain.

On September 5, 2000, Claimant returned to Life Resource for psychiatric follow-up and was prescribed Zoloft, Buspar, Risperdal and Doxepin by Dr. Tuttle for depression treatment. (EX-1, pp. 231-53). Claimant's diagnosis was changed to depression with psychotic features. On October 18, 2000, Claimant was treated at Life Resource for continued psychiatric problems and medication maintenance.

On November 27, 2000, Dr. Williamson examined Claimant again and found severe degenerative changes in Claimant's back and neck. (EX-14, p. 14). Dr. Williamson noted that Claimant had been taking Vicodin due to his prior mentioned partial medial meniscectomy, but Dr. Williamson did not think it was advisable for Claimant to continue taking Vicodin. On January 9, 2001, Dr. Williamson noted in Claimant's chart that Dr. Johnston was reportedly still prescribing Claimant Vicodin. (EX-14, p. 38).

On December 7, 2000, Dr. Williamson ordered myelographic evaluations and CT scans of Claimant's cervical, thoracic and lumbar spine, which indicated Claimant to have: (1) canal stenosis at L2 to L5; (2) left paracentral protrusion at T7-8 to the anterior aspect of the cord with multiple level thoracic degenerative disease; and (3) multiple level cervical degenerative disease with cord atrophy at C4-5, status post decompression with corpectomy from 3 to 5 with multiple level foraminal narrowing. (EX-14, pp. 15, 17-22). Dr. Williamson called Claimant on January 29, 2001, reporting the just reviewed test results and recommending that Claimant follow up with Dr. Williamson. Claimant had not been back to see Dr. Williamson at the time of the hearing. (Tr. 119).

On January 26, 2001, Dr. Martin R. Haig examined Claimant and took a careful history from Claimant reviewing Claimant's alleged workplace injury. Dr. Haig reviewed all of the medical records in preparation for said examination, which was documented in a January 30, 2001 letter to Michael K. Eaves with Benckenstein & Oxford, Employer's counsel. (EX-4). Dr. Haig recounted Claimant's medical treatment history for his back and neck injuries. Claimant reported to Dr. Haig that on or about June 10, 1999, he was working as a pipefitter helper for Employer when he bumped and injured his head going in and out of a hole. Nevertheless despite soreness and stiffness in his neck he continued to work for Employer until June 14, 1999. Claimant denied any neck or low back injuries previous to his alleged June 10, 1999 workplace injury. Dr. Haig's examination showed Claimant was able to get on and off the exam table with no discomfort in the low back, and no toe paralysis was noted. Dr. Haig completed cervical spine x-rays, which revealed that Claimant had undergone a fairly massive cervical fusion.

Dr. Haig opined that Claimant could do any medium type work not involving heavy lifting. Dr. Haig testified that Claimant could lift ten to fifteen pounds at shoulder level for “awhile,” and could do any sitting down type of job, but could not do heavy work because of his neck surgery.

On January 26, 2001, Claimant also met with vocational rehabilitation expert Deborah Smith (Smith). (EX-6). Following her January 26, 2001 meeting with Claimant, Smith completed a transferable skills analysis on Claimant, as well as completing two labor market surveys (LMS), with each LMS identifying ten potential positions for Claimant. Claimant has not worked for anyone for wages since June 12, 1999, his last day of work for Employer, stating that he has been unable to hold full time employment. (Tr. 147-49). Conversely, Claimant collected unemployment benefits from November of 1999, to May of 2000, based on the fact that Claimant informed the unemployment office every two weeks that he was able to work full time, five days a week. (Tr. 159-61).

## **B. Claimant’s Testimony**

Claimant recounted his medical treatment, alleged workplace accident, personal and work history. Claimant testified that he was physically fit up until the time of his workplace accident. (Tr. 167). Conversely, the records indicate that Claimant had a torn medial meniscus in his left knee dating back to at least September of 1998, which caused him significant problems, and a history of intravenous drug abuse. Moreover, Claimant was in the hospital on October 23, 1998, for stomach pain. (EX-1, pp. 1-10, 112, 222-24).

Concerning the alleged “injury,” Claimant gave conflicting accounts testifying that on June 10, 1999, he went into a hole feet first, slipped off a ladder while holding onto a rail outside of the hole and when he climbed back up, he jammed his head against a manhole and felt pain in his lower back. (Tr. 28,29, 130-131, 167-74). Claimant’s first written report to Employer on July 2, 1999, contains no mention of head trauma and places the “injury” between June 10 and 13, 1999. (Tr. 120, 128-31; EX-10). Claimant’s second written report to Employer on July 30, 1999, attributes the head trauma to striking his head on overhead pipes. (EX-11).

Claimant testified that he was aware of Employer’s policy that employees were to report accidents as soon as they happened. (Tr. 64-65, 82-83). Nonetheless, Claimant made no report of an injury to his back until July 2, 1999, and no report of injury to his neck until July 30, 1999. (Tr. 66-72, 82-89).

Claimant further testified that following his June 10, 1999, workplace accident, on June 14, 1999, he called work and reported to Jimmy Obregon, who was the brother of the person who was secondary to Claimant’s supervisor, that he was going to see a doctor. (Tr. 70-72, 82-89, 122). Claimant did not tell Obregon that he was hurt and provided conflicting testimony saying that most likely he did not call Obregon more than once or twice and also testifying that he called Obregon all the time, almost every day. (Tr. 88). Claimant testified that any lack of calls to Employer was due to the fact that Dr. Reyes had given Claimant a couple of weeks off of work. (Tr. 89).

Not only were there no witnesses to Claimant's injury, the medical records do not support Claimant's version of events. Concerning his initial visit to Park Place Hospital ER on June 14, 1999, Claimant testified that he complained of back pain. The medical records do not reflect any complaints of back pain or neck pain on June 14, 1999. (Tr. 73-76; EX-1). Claimant did not relate his illness to a workplace accident when he presented to the ER on June 14, 1999, with a headache, sore throat and fever, but nonetheless testified that he knew that he had injured himself at work. (EX-7; Tr. 69, 76-78). Claimant also did not report to Dr. Reyes, who first examined Claimant on June 15, 1999, that he had injured himself on the job or that he had injured his back and/or neck; although Claimant testified that he presented to Dr. Reyes with complaints of pain in his back and legs. (Tr. 80-81).

Claimant further testified that when he went to see Dr. Reyes on June 17, 1999, he specifically requested an MRI or x-rays, but Dr. Reyes refused saying it was too expensive, even though Claimant informed Dr. Reyes that he had good health insurance. In fact, upon his June 17, 1999 examination of Claimant, Dr. Reyes recommended x-rays of Claimant's lumbosacral area, which were completed on June 22, 1999, and indicated a congenital defect of the spine. (Tr. 84-85; EX-1, pp. 32-34).

On June 29, 1999, Claimant saw Dr. Fleming due to knee pain. Claimant admitted he did not report to Dr. Fleming that he had injured himself at work on June 10, 1999. Dr. Fleming referred Claimant to see Dr. Johnston, who Claimant saw on July 6, 1999. Claimant admitted he did not report to Dr. Johnston that he had injured himself at work. (Tr. 96-98; EX-1, p. 48). Furthermore, Claimant testified that he experienced no neck pain and did not realize he had neck problems until he saw his cervical MRI and Dr. Johnston told him that he had problems in his neck and lower back. (Tr. 129, 178; EX-1, pp. 42-47).

Claimant testified that Dr. Williamson's records of their July 26, 1999 office visit were incorrect in that they reflected Claimant to have told Dr. Williamson that his alleged workplace accident occurred on June 7, 1999, climbing out of hole, when the incident occurred on June 10, 1999, climbing into a hole. (Tr. 107-09). Claimant had also reported to Dr. Williamson that he related his neck and lower back problems to the alleged June 10, 1999, workplace accident, when he noticed increased pain within his back, as well as some pain within his neck. (Tr. 106-08). Contrary to Claimant's earlier statement that he never knew he had neck pain until Dr. Johnston showed him his cervical MRI, Claimant related that the onset of his symptomology, including neck pain, was earlier than June 7, 1999, when he informed Dr. Williamson that he had sustained his neck injuries because he often bumped his head on pipes while at work. (Tr. 138-41).

Claimant testified that he has not worked since June 12, 1999, because he has been unable to hold full time employment. (Tr. 147-49). Still, Claimant admitted that around the time of his alleged injury in mid June of 1999, he helped his brother install a hot water heater. Claimant classified this work as very light. (Tr. 100). Claimant also admitted that he worked at church and was able to climb a six foot ladder to cut some limbs off the top of his house with loop cutters, and only after cutting several limbs did his back

and neck simultaneously begin to hurt. (Tr. 147-49). Subsequent to his alleged workplace accident, Claimant also cut his grass, used a weed eater and washed his car.

Claimant testified that he began looking for a job in March of 2001, and that he wanted to work. (Tr. 150-58). Conversely, TRC reported that Claimant voluntarily closed his case because Claimant reported to TRC that he had chosen to pursue Social Security benefits. (Tr. 201). Additionally, Claimant testified that Smith was badgering him, so he merely agreed with her and stated he wanted to go to work.

Moreover, Claimant testified that on November 14, 1999, the unemployment office informed him that in order to get unemployment benefits he had to physically be able to work. Thus, on November 17, 1999, Dr. Williamson released Claimant to work sedentary duty. Subsequently, Claimant began receiving unemployment benefits. (Tr. 159-61). Claimant collected unemployment benefits from November of 1999, to May of 2000, based on the fact that Claimant informed the unemployment office every two weeks that he was able to work full time, five days a week.

Claimant further testified that he did not remember speaking with Dr. Hales' office on September 9, 1999, or on July 17, 2000, as described above, regarding two physicians giving him prescriptions for pain medication. (Tr. 110-12, 115; EX-1, p. 119). Also in contradiction to the record, Claimant testified that Dr. Vadva informed him that he did not test positive for Hepatitis C. (Tr. 109). The record reflects, however, that Claimant was informed on several occasions by various physicians, including Dr. Vadva, that he tested positive for Hepatitis C. On August 27, 1999, Dr. Williamson informed Claimant by certified letter, which was duly received and signed for by Claimant on September 7, 1999, that he tested positive for Hepatitis C. (EX-1, p. 93). On September 16, 1999, and October 21, 1999, Claimant saw Dr. Vadva specifically due to his positive Hepatitis C test results. (EX-1, p. 112).

Additionally, Claimant denied telling Dr. Haig when they met on January 26, 2001, that his back was stiff, but improving, as indicated by Dr. Haig's records concerning Claimant's treatment. (Tr. 117-19). Conversely, Claimant testified that Dr. Williamson informed him he would need back surgery if he continued to have back pain.

### **C. Claimant Witness, Bernadine Minix**

Bernadine Minix (Minix), Claimant's wife of nine years, testified that prior to June 10, 1999, Claimant worked continuously with no problems. (Tr. 181). Minix testified that Claimant had no other accidents prior to the alleged June 10, 1999 workplace accident and that prior to that accident, Claimant led a very active lifestyle.

Minix testified that she brought Claimant to the ER around June 10, 1999, because Claimant was experiencing fatigue and tingling in his hands. Minix testified Claimant did not report to the ER upon that

visit, or to Dr. Reyes upon follow up visits, that he was injured at work because Claimant did not know at that time he was injured at work. (Tr. 184-85). Minix testified that Claimant had no medical problems prior to his alleged June 10, 1999 workplace accident, but after further questioning admitted that Claimant had “a little” problem with his knee in the previous year. (Tr. 186).

Minix further testified when Claimant visited Dr. Reyes, Claimant requested x-rays and MRIs, but was informed that they were expensive and Dr. Reyes refused such treatment even after Claimant and Minix informed Dr. Reyes that Claimant had good insurance coverage. (Tr. 182-83). Conversely, the record reflects that Dr. Reyes recommended and completed x-rays of Claimant’s lumbosacral area upon his June 22, 1999 examination of Claimant. (EX-1, pp. 28-30, 32-34).

Minix testified that Claimant called Employer numerous times. (Tr. 187). This testimony elicited from Minix was presumably related to Claimant informing Employer that he would not be reporting to work after June 12, 1999, but such information was not specified by Minix’s testimony. Minix further testified that she was not aware of any phone calls from Dr. Hales that Claimant needed only one physician to prescribe medication and that she was not concerned about Claimant’s use of Vicodin because he was not a drug user, contrary to the record which indicates Claimant has a history of intravenous drug use. (EX-1, pp. 112, 222-24).

Moreover, Minix testified that Claimant was not taking any medication at the time of the April 3, 2001 hearing. However, Dr. Hales records indicate that Claimant was regularly taking Vioxx, Trizec, Glucotrol, Accuretic, Altace, aspirin and Vicodin and had been prescribed said medications upon Dr. Hales’ most recent March 8, 2001 examination of Claimant. (EX-14, p. 8).

#### **D. Claimant Witness, Hattie Bailey**

Hattie Bailey (Bailey), Claimant’s sister, testified that she has seen a change in Claimant’s condition since his alleged June 10, 1999 workplace accident. Specifically, Claimant now has difficulty getting in and out of a truck and no longer helps around the house or plays sports with Bailey’s son. (Tr. 189-90).

Bailey testified that since his alleged June 10, 1999 workplace accident, Claimant complains of back and neck pain. She testified that he had no prior accidents of any kind other than the alleged workplace accident which is the subject of the instant claim. Additionally, Bailey testified Claimant never sought psychological help prior to seeing Dr. Wright. (Tr. 191-92).

#### **E. Vocational Rehabilitation Expert, Deborah Miller Smith**

Smith, vocational rehabilitation expert, testified at the hearing concerning Claimant’s employability and the vocational rehabilitation analysis she completed on January 26, 2001. (Tr. 195-226; EX-6). Smith testified that Claimant reported to her that he was interested in returning to work. (Tr. 196-97). Nevertheless, Smith questioned Claimant’s desire to return to work because Claimant had previously

informed Wright that he did not think he could survive without disability benefits.

Prior to her January 26, 2001, meeting with Claimant, Smith reviewed: (1) Claimant's deposition dated October 9, 2000; (2) Claimant's answers to interrogatories dated August 17, 2000; (3) numerous medical records, including the sedentary job release dated November 17, 1999, by Dr. Williamson and Wright's August 23, 2000, psychological evaluation of Claimant; (4) Dr. Haig's January 30, 2001, report on Claimant; and (5) Claimant's job application for Employer dated September 9, 1998.

Smith had previously issued a report on October 18, 2000, concerning Claimant's employability, which report was based on information she extrapolated from items one to three above. (EX-6). In essence, that report stated Claimant was employable in a variety of settings, taking into consideration the restrictions assigned by Dr. Williamson on November 17, 1999, and Smith identified several positions that were available near Claimant's home.

Following her January 26, 2001, meeting with Claimant, Smith completed a transferable skills analysis. Smith found Claimant had many residual skills which made him employable. She completed two labor market surveys (LMS), a then current LMS and a retrospective LMS, with leads from about June of 2000, with each LMS identifying ten positions. The retrospective positions were identified from logs of job openings Smith had kept since 1995. The then current LMS identified jobs from the sedentary to medium category, with salaries from \$6.00 hourly to \$9.00 hourly. The only position within the sedentary restrictions set forth by Dr. Williamson was with Express Personnel, which job involved receiving orders for many types of light industrial work and paid \$7.00 to \$9.00 hourly.

#### **IV. DISCUSSION**

It has been consistently held that the Act must be construed liberally in favor of the Claimant. *Voris v. Eikel*, 346 U.S. 328, 333, 74 S. Ct. 88, 98 L. Ed. 5 (1953); *J. B. Vozzolo, Inc. v. Britton*, 377 F. 2d 144 (D.C. Cir. 1967). The United States Supreme Court, however, has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L. Ed. 2d 221 (1994).

##### **A. Contentions of the Parties**

Claimant asserts that: on unspecified days in June, 1999, he sustained multiple head traumas by hitting his head on overhead pipe as he climbed in and out of portholes. These traumas culminated in a June 10, 1999, neck injury which Claimant sustained after he went a manhole, slipped, hurt his back, and in the process of pulling himself upright, struck and jammed his head, causing severe pain and resulting in eventual neck surgery on August 20, 1999, by Dr. Williamson. For this alleged injury Claimant seek temporary total

disability (TTD) from June 15, 1999, through November 17, 1999. Thereafter Claimant seeks permanent total disability (PTD) because of his inability to perform his past pipefitting work or any other suitable employment given his physical and mental limitations. Claimant also seeks additional relief but does not specify what such involves. Presumably Claimant seeks reimbursement for medical expenses associated with the alleged June 10, 1999 injury plus attorney fees and expenses.

Employer/Carrier asserts that: (1) Claimant never injured himself at work as manifested by inconsistent stories about the date and manner of the alleged accident and Claimant's failure to timely report the alleged accident (*See Bolden v G.A. T. X . Terminals Corp.* 30 BRBS 71 (1996)); (2) assuming arguendo that Claimant showed he suffered a physical harm as a result of a work place accident, thereby invoking a Section 20 (a) presumption, Employer presented substantial countervailing evidence to not only rebut the presumption but show that Claimant's back and neck condition is degenerative and congenital in nature and not work related; (3) assuming arguendo that Claimant established a work related disability, such disability is only partial at best, due to Claimant's wage earning capacity of \$280.00 to \$360.00 per week. (*See Louisiana Insurance Guaranty Association v. Abbott*, 40 F.3d 1222, 126 (5<sup>th</sup> Cir. 1994)); and (4) Claimant is not due any medical benefits because Claimant has never requested payment of such.

## **B. Credibility**

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. *Duhagon v. Metropolitan Stevedore Company*, 31 BRBS 98, 101(1997); *Avondale Shipyards, Inc. v. Kennel*, 914 F.2d 88, 91 (5th Cir. 1988); *Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce*, 551 F. 2d 898, 900 (5th Cir. 1981); *Bank v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467, 88 S. Ct. 1140, 20 L. Ed. 2d 30 (1968).

### **B(1) Claimant**

In general I was not impressed by Claimant's testimony which was unsupported by any witnesses and often contradictory concerning the date, symptoms and manner of the alleged injury. Although Claimant alleged that he was injured between June 10 & 13, 1999, the medical records show no report of the work place injury until July 26, 1999, when Claimant asserted to Dr. Williamson he began to have neck and back pain on June 7, 1999, while climbing out of a ship hole. Claimant did not even report the alleged accident to Employer until July 2, 1999, ten days after his initial termination, and then asserted the injury occurred somewhere between June 10 and 13, 1999.<sup>4</sup> Claimant gave no reason for his failure to report the injury to Employer sooner and gave no reason why he failed to relate the injury to treating

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<sup>4</sup> On his LS 203 Claimant asserted the injury occurred on June 14, 1999. (EX-9, p. 3).

physicians Drs. Reyes, Fleming, Johnston and Hales.

Claimant gave multiple inconsistent statements in the record. Claimant testified that he complained of back pain on his initial visit to Park Place Hospital ER on June 14, 1999, but the medical records do not reflect any such complaints. (Tr. 73-76; EX-1). Claimant stated that Dr. Reyes refused to authorize x-rays on June 17, 1999, but the record reflects that Dr. Reyes recommended x-rays of Claimant's lumbosacral area, which were completed on June 22, 1999. (Tr. 84-85; EX-1, pp. 32-34). Similarly, Claimant did not report to either Dr. Fleming on June 29, 1999, or Dr. Johnston, on July 6, 1999, that he had injured himself at work. (Tr. 96-98; EX-1, p. 48). Claimant testified that he never experienced neck pain, yet he related his neck problem to his workplace injury after reviewing a MRI of his cervical spine and testified that he experienced neck pain, during the time of his accident because he often bumped his head on pipes while at work. (Tr. 129, 138-41, 178; EX-1, pp. 42-47).

In addition to inconsistencies between Claimant's statement and the medical records, Claimant represented to the unemployment office that he was able to work full time, without restrictions between November 1999, and May 2000, when Claimant is seeking permanent total disability in this proceeding because of his inability to perform any suitable alternative work. On at least two occasions, Claimant attempted to inflate his ability to obtain prescription medication by having two doctors prescribe pain killers. Furthermore, Dr. Wright, a psychologist, described Claimant as a learned con artist, and diagnosed Claimant with psychotic features. Accordingly, I find a sufficient basis in the record to discredit the testimony of Claimant.

## **B(2) Bernadine Minix**

In like manner I was not impressed with Claimant's wife's testimony which was contradicted by the medical records and exhibits. Specifically, Minix testified that Claimant had no prior medical problems prior to the June 1999 accident, but upon further questioning admitted that Claimant had a "little" problems with his knee the previous year. Like Claimant, Minix testified that Dr. Reyes refused to authorize x-rays and MRIs, but the medical records indicate that such were ordered by Dr. Reyes. Minix denied any knowledge of a phone call from Dr. Hales relating that Claimant needed only one physician to prescribe medication. Minix testified that Claimant was not a drug user, when in fact Claimant has a history of intravenous drug use. Finally, Minix testified that Claimant was not taking any medication at the time of the April 3, 2001 hearing, when Dr. Hales prescribed pain medication as recently as March 8, 2001. Accordingly, I find that Minix did not make a credible witness.

## **C. Causation**

To prove entitlement to benefits, Claimant must show that he suffered a harm caused by his employment. *Graham v. Newport News Shipbuilding & Dry Dock Co.*, 13 BRBS 336, 338 (1981). Section 20 provides that "[i]n any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary - - (a) that the claim comes

within the provisions of this Act.” 33 U.S.C. § 920(a) (2000); *Kubin v. Pro-Football, Inc.*, 29 BRBS 117, 119 (1995); *Addison v. Ryan Walsh Stevedoring Co.*, 22 BRBS 32, 36 (1989); *Leone v. Sealand Terminal Corp.*, 19 BRBS 100, 101 (1986). To rebut the Section 20(a) presumption, the Employer must present substantial evidence that a claimant’s condition is not caused by a work-related accident or that the work-related accident did not aggravate Claimant’s underlying condition. *Port Cooper/T Smith Stevedoring Co. v. Hunter*, 227 F.3d 285, 287 (5<sup>th</sup> Cir. 2000); *Gooden v. Director, OWCP*, 135 F.3d 1066, 1068 (5<sup>th</sup> Cir. 1998). Under the Administrative Procedures Act, a claimant has the ultimate burden of persuasion by a preponderance of the evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281, 114 S. Ct. 2251, 129 L. Ed 2d. 221 (1994).

Under the aggravation rule, an entire disability is compensable if a work related injury aggravates, accelerates, or combines with a prior condition. *Independent Stevedore Co. v. O’Leary*, 357 F.2d 812, 814-15 (9<sup>th</sup> Cir. 1966); *Kubin*, 29 BRBS at 119. The term injury includes the aggravation of a pre-existing non-work-related condition or the combination of work- and non-work-related conditions. *Lopez v. Southern Stevedores*, 23 BRBS 295, 297 (1990). All factual doubts must be resolved in favor of the claimant. *Morehead Marine Services, Inc. v. Washnock*, 135 F.3d 366, 371 (6<sup>th</sup> Cir. 1998) (quoting *Brown v. ITT/Continental Baking Co.*, 921 F.2d 289, 295 (D.C. Cir. 1990)); *Wright v. Connolly-Pacific Co.*, 25 BRBS 161, 168 (1991).

### **C(1) Prima Facie Case**

Section 2(2) of the Act defines “injury” as “accidental injury or death arising out of or in the course of employment.” 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

In any proceeding for the enforcement of a claim for compensation under this Act **it shall be presumed**, in the absence of substantial evidence to the contrary, that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a)(emphasis added).

To establish a *prima facie* claim for compensation, a claimant need not affirmatively establish a connection between the work and the harm. Rather, a claimant has the burden of establishing only that: (1) the claimant sustained physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129 (1984). “[T]he mere existence of a physical impairment is plainly insufficient to shift

the burden of proof to the employer.” *U.S. Industries/Federal Sheet Metal Inc., v. Director, OWCP*, 455 U.S. 608, 102 S. Ct. 1312, 71 L. Ed. 2d 495 (1982). Once both elements of the *prima facie* case are established, a presumption is created under Section 20(a) that the employee’s injury or death arose out of employment.

### **C(1)(a) Existence of Physical Harm or Pain**

Claimant has established that he suffers from a physical harm. Specifically, on June 22, 1999, Dr. Reyes discovered a congenital spinal defect. (EX 1, p. 34). Dr. Reyes reached this conclusion after reviewing five views of Claimant’s lumbar spine that revealed a questionable small neural arch deficit or spondylolysis at the right L5 level. *Id.* An MRI of the cervical spine, taken on July 7, 1999, indicated marked central cord compression secondary to a large central intervertebral disc herniation at C4-5 and a smaller disc herniation at C3-4, resulting in focal spinal stenosis. (EX 1, p. 43). An MRI of the lumbar spine, taken on July 8, 1999, indicated a grade four or five intervertebral disc extrusion or possibly sequestration at the L5-S1 level, and a moderate protrusion at the L4-5 level. (EX 1, p. 44). Accordingly, Claimant established the first element of a *prima facie* case in that he suffered a physical harm or pain.

### **C(1)(b) Establishing That an Accident Occurred in the Course of Employment, or That Conditions Existed at Work, Which Could Have Caused the Harm or Pain**

Uncorroborated testimony by a discredited witness is insufficient to establish the second element of a *prima facie* case that the injury occurred in the course and scope of employment, or that condition existed at work that could have caused the harm. *Alley v. Julius Garfinckel & Co.*, 3 BRBS 212, 214-15 (1976)(finding the claimant’s uncorroborated testimony on causation not worthy of belief); *Smith v. Cooper Stevedoring Co.*, 17 BRBS 721, 727 (1985)(ALJ)(finding that the claimant failed to meet the second prong of establishing a *prima facie* case because the claimant’s uncorroborated testimony linking the harm to his work was not supported by the record). For a traumatic injury case, the claimant must show a specific traumatic event, more than just working conditions that required repetitive bending, stooping, climbing, or crawling. *Leblanc v. Cooper/T. Stevedoring, Inc.*, 130 F.3d 157, 160-61 (5<sup>th</sup> Cir. 1997)(finding that back injuries due to repetitive lifting, bending and climbing ladders are not peculiar to employment and are treated as traumatic injuries); *Gencarelle v. General Dynamics Corp.*, 892 F.2d 173, 177-78 (2<sup>nd</sup> Cir. 1989)(finding that a knee injury due to repetitive bending stooping, squatting and climbing is not an occupational disease). Conditions that are due to congenital and degenerative factors do not constitute a compensable injury. *Lennon v. Waterfront Transport*, 20 F.3d 658, 662 (5<sup>th</sup> Cir. 1994); *Director v. Bethlehem Steel Corp.*, 620 F.2d 60 (5<sup>th</sup> Cir. 1980). Thus, a claimant’s failure to show an antecedent event will prohibit the claimant from establishing a *prima facie* case and his entitlement to the Section 20 presumption of causation

In *Bolden v. G.A.T.X. Terminals, Corp.*, 30 BRBS 71, 72-73 (1996), the Board affirmed a denial of benefits when the ALJ determined that the claimant was not a credible witness and negated the claimant's contentions that he suffered a work related accident. Specifically the claimant related his injury to a specific traumatic event, but the ALJ noted: 1) the claimant was confused over the date of the incident; 2) a physician remarked that the claimant had experienced pain two weeks prior to the alleged accident; 3) neither the claimant nor his physician related the pain to the claimant's work during soon after the alleged event occurred; and 4) the claimant failed to report the injury to his employer promptly. *Id.* at 72. Similarly, the ALJ discredited the testimony of the claimant's co-workers and wife because their statements concerning the claimant's physical condition did not establish the date of the alleged traumatic event. *Id.* Finally, the ALJ noted that no physician, outside of those who took the claimant's version of events at face value, could establish that a specific event cause the claimant's injuries. *Id.* at 72-73. Accordingly, the claimant in *Bolden* failed to establish the second prong of the *prima facie* case because he failed to establish that a traumatic event, or conditions that existed at work, could have caused his harm. *Id.* at 73.

Similar to *Bolden*, Claimant fails to establish that he suffered an accident that occurred in the course of his employment or that a condition existed at work which could have caused the harm or pain. As noted *supra*, I do not find Claimant to be a credible witness and his uncorroborated testimony alone is insufficient to establish a *prima facie* case. Specifically, I find: 1) Claimant gave numerous conflicting dates on when the alleged event occurred, ranging from June 7, 1999, to June 14, 1999; 2) when Claimant went to the emergency room on June 14, 1999, he complained of a headache, sore throat, and a fever, and never mentioned any problem with his back and neck; 3) Claimant did not complain of a back or neck problem until June 22, 1999, well after the alleged event occurred; 4) Dr. Reyes diagnosed a *congenital* spinal defect; 4) Dr. Williamson diagnosed *degenerative* changes in Claimant's back; 5) Dr. Haig testified that it takes years to develop spinal stenosis; 6) Claimant did not fill out an accident statement promptly; 7) neither Claimant's wife or sister could relate that Claimant suffered from a specific event, only that they noticed a change in Claimant's condition; 8) Claimant related that he hit his head constantly while at work and could not point to a specific event that created the onset of his neck symptoms; and 9) no physician of record specifically related Claimant's medical condition to the alleged event outside of Claimant's self-serving statements.<sup>5</sup> Therefore, I find that Claimant has failed to establish a *prima facie* case of compensation under the Act and DENY his entitlement to benefits.<sup>6</sup>

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<sup>5</sup> Indeed, Dr. Williamson reported several months of problems, pre-dating the alleged injury, in his July 26, 1999 report. (EX 1, p. 65).

<sup>6</sup> In the alternative, should the Board determine that Claimant met his *prima facie* case for compensation, this same evidence, combined with Claimant's lack of credibility, constitutes substantial evidence sufficient to rebut the presumption of causation, and once the presumption is no longer applicable, this same evidence establishes, based on the record as a whole, that Claimant's current condition is not work related.

## **V. ORDER**

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I find that Claimant has not established that an event or condition at work caused his harm. Therefore, Claimant's petition for benefits under the Act is DENIED.

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CLEMENT J. KENNINGTON

Administrative Law Judge